

**Appendix to
Tennessee Department of Health:
Tennessee Clinical Practice Guidelines for Outpatient
Management of Chronic Non-Malignant Pain**

**Division of Workers' Compensation
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Background

Opioids (Narcotics) and other associated analgesic medications represent more than 30% of drug costs in Tennessee Workers' Compensation claims, a significant portion of payments for long term claimants, and are associated with longer periods of disability and lost-work time.

Effective oversight and appropriate use of these medications reduce their abuse and diversion, return injured workers to employment sooner, decrease long term disability, improve longevity, and improve patient function.

There are special situations in workers' compensation that are addressed by this appendix. Each patient is assigned an "authorized treating physician." In Tennessee Code Annotated § 50-6-204(j)(2)(B), there are educational requirements and "board" criteria to be a "qualified physician" and treat chronic pain with opioids. These requirements are similar to but somewhat different than those in the Department of Health Guidelines as a "Pain Medicine Specialist" and it is anticipated that future legislation will be passed to reconcile the differences.

Employers through their workers' compensation insurance carriers and utilization review companies may review Schedule II, III, and IV prescriptions for appropriateness, necessity, and efficacy after 90 days. The co-administration of other Schedule II, III, and IV medications with opioids significantly increases the probability of serious complications, including death, and should generally not be used.

If more than one provider is prescribing any of the medications listed in these guidelines, each must access the CSMD at each visit and assure by direct telephone or face-to-face communication that each provider is aware of the safety and appropriateness of all prescribed medications given to an individual patient. This communication should occur at least quarterly and be documented in the chart. As a result of the risks of treatment with these medications, it is important to set guidelines that may aid the practitioners and the injured workers in effectively and safely managing chronic pain.

This Appendix is intended as a reference guide concerning the management of scheduled medications in Workers' Compensation and should be used in association with the Department of Health "Tennessee Clinical Practice Guidelines for Outpatient Management of Chronic Non-malignant Pain", and the Department of Health Brochure, "If Opioids Have Not Relieved Your Chronic Pain". See:

<http://health.tn.gov/Downloads/ChronicPainGuidelines.pdf>

<https://health.state.tn.us/Downloads/Opioids%20Education%20Piece%20FINAL.pdf>.

Dosages up to 90 days, less than or equal to 100MEDD¹:

The authorized treating physician may prescribe opioids for injured Workers' Compensation patients for up to 90 days after injury or after major surgery.

If the opioid dose is less than 100MEDD and does not include any of the following:

- a. both long and short acting opioids,
- b. fentanyl, Butrans patch, methadone, carisoprodol, benzodiazepines (or their derivatives),
- c. "sleeping pills" (e.g. eszopiclone, ramelteon, triazolam, zaleplon, zolpidem, etc), or
- d. "muscle relaxants",

then the authorized treating physician may prescribe the opioids to the Workers' Compensation patient.

If the opioid dose is less than 100MEDD, and does include any of the following:

- a. both long and short acting opioids,
- b. fentanyl, Butrans patch, methadone, carisoprodol, benzodiazepines (or their derivatives),
- c. "sleeping pills" (e.g. eszopiclone, ramelteon, triazolam, zaleplon, zolpidem, etc.), or
- d. "muscle relaxants",

then a one-time consultation with a Pain Medicine Specialist (as defined by the DOH) who is also a "qualified physician" (See T.C.A. § 50-6-204(j)(2)(B)) must be scheduled and must occur. The initial evaluation must be with the "pain specialist" and not with a mid-level provider working under the supervision of the physician.

Dosages up to 90 days, greater than 100MEDD:

Prescriptions for all psychoactive and sedative medications and all analgesic medications in patients taking over 100 MEDD should be written and signed by the authorized treating physician or a Pain Medicine Specialist who has examined the patient that same day, and not by a mid-level provider working under the supervision of the physician.

When these other medications are prescribed for co-morbid mental illness rather than pain management, the authorized treating physician or Pain Medicine Specialist/qualified physician may only write the initial scheduled pain medication prescriptions at this high a dose after direct in-person or telephone consultation with the Psychiatrist or primary care physician who is also treating the patient. Any increase in drug dosage or change in drugs used for pain management may only occur after direct person-to-person or telephone consultation with the Psychiatrist/primary care physician treating the patient. If the other prescriber is a non-physician, communication

¹ The total daily dose of opioid will be assumed to be that reported on the Tennessee Controlled Substance Database report for the current dose, MEDD means morphine equivalent daily dose.

should be with the supervising physician for the mid-level provider, and the physician supervising the mid-level provider should assume the care of patient for the duration of opioid therapy at this level.

Only one physician should be prescribing all controlled substances for chronic pain management when opioid doses are this high, and if a mental illness is present, only one additional physician/psychiatrist should prescribe all other controlled substances and psychoactive substances for the mental illness.

When a Workers' Compensation patient is being prescribed chronic opioids, and that patient is also being prescribed other scheduled medications for a co-morbid mental or sleep disorder by a non-psychiatrist, use of chronic opioids for pain is generally not appropriate. If the "other prescriber" is willing to transfer care to the workers' compensation authorized treating physician, the authorized treating physician can plan and supervise the tapering and weaning of the patient off the non-opioid other medications. The required office visits would be the responsibility of the workers' compensation employer/insurer, but the cost of the other medications prescribed for the co-morbid mental illness or sleep disorder would not be the responsibility of the employer/insurer during the tapering/weaning, except where the mental illness has been accepted as work related.

If the authorized treating physician is already a "qualified physician" (See T.C.A. § 50-6-204(j)(2)(B)) for chronic opioid therapy, and if the dose of opioid (Schedule II, III, IV) exceeds 100MEDD, a one-time consultation with a Pain Consultant/Pain Medicine Specialist, as defined by the DOH "Clinical Practice Guidelines for the Management of Chronic Pain", should be made. The current opioid treatment plan may continue until the consultation occurs and results have been received by the authorized treating physician.

If the authorized treating physician is not already a "qualified physician" for chronic opioid therapy, based on the risk associated with this dose, pain management treatment should be transferred to a Pain Medicine Specialist (DOH criteria) who also meets criteria for a "qualified physician." The initial evaluation must be by the "qualified physician" and not by a mid-level provider working under the supervision of the physician.

Dosages over 90 days, less than 100MEDD:

If the authorized treating physician is not already a "qualified physician", at this point, T.C.A. § 50-6-204(j)(1) requires transfer of care to a "qualified physician" (See T.C.A. § 50-6-204(j)(2)(B)). Utilization review of the chronic opioid therapy should not occur until after the transfer of care is complete, and the new "qualified physician" has established a treatment plan.

For those patients receiving opioid treatment for longer than 90 days:
If the opioid dose is less than 100MEDD and does not include any of the following:

- a. both long and short acting opioids,
- b. fentanyl, Butrans patch, methadone, carisoprodol, benzodiazepines (or their derivatives),

- c. “sleeping pills” (e.g. eszopiclone, ramelteon, triazolam, zaleplon, zolpidem, etc), or
- d. “muscle relaxants”,

then the authorized treating physician (“qualified physician”) may prescribe the opioids to the Workers’ Compensation patient.

If the opioid dose is less than 100MEDD, and does include any of the following:

- a. both long and short acting opioids,
- b. fentanyl, Butrans patch, methadone, carisoprodol, benzodiazepines (or their derivatives),
- c. “sleeping pills” (e.g. eszopiclone, ramelteon, triazolam, zaleplon, zolpidem, etc), or
- d. “muscle relaxants”,

then the care should be transferred to a Pain Medicine Specialist (as defined by the DOH) who is also a “qualified physician”. The initial evaluation must be with the “Pain Medicine Specialist” and not with a mid-level provider working under the supervision of the physician.

Dosages over 90 days, over 100MEDD:

For patients taking doses of greater than 100MEDD for over 90 days, pain management treatment should be provided by a Pain Medicine Specialist (DOH criteria) who is also a “qualified physician” (See T.C.A. § 50-6-204(j)(2)(B)).

Prescriptions for all psychoactive and sedative medications and all analgesic medications in patients taking over 100 MEDD should be written and signed by the authorized treating physician, a Pain Medicine Specialist, who has examined the patient that same day, and not by a mid-level provider working under the supervision of the physician.

When these other medications are prescribed for co-morbid mental illness rather than pain management, the Pain Medicine Specialist/qualified physician may only write the initial scheduled pain medication prescriptions after direct in-person or telephone consultation with the Psychiatrist also treating the patient. Any increase in drug dosage or change in drugs used for pain management may only occur after direct person-to-person or telephone consultation with the Psychiatrist treating the patient. Only one physician should be prescribing all controlled substances for chronic pain management when opioid doses are this high, and if a mental illness is present, only one additional physician/psychiatrist should prescribe all other controlled substances and psychoactive substances for the mental illness.

When a Workers’ Compensation patient is being prescribed chronic opioids, and that patient is also being prescribed other scheduled medications for a co-morbid mental or sleep disorder by a non-psychiatrist, use of chronic opioids for pain is generally not appropriate. If the “other prescriber” is willing to transfer care to the

workers' compensation authorized treating physician, the authorized treating physician can plan and supervise the tapering and weaning of the patient off the non-opioid other medications. The required office visits would be the responsibility of the workers' compensation employer/insurer, but the cost of the other medications prescribed for the co-morbid mental illness or sleep disorder would not be the responsibility of the employer/insurer during the tapering/weaning, except where the mental illness has been accepted as work related.

If the co-morbid mental illness appears during tapering to require continued treatment with one or more other scheduled medications or anti-psychotics or anti-convulsants, a Psychiatrist should be consulted for help with managing the mental illness during chronic pain management. The psychiatric evaluation and treatment is not the financial responsibility of the employer/insurer, unless the mental illness is accepted as work related.

The physician should do a face-to-face examination at least six times yearly if the patient is on any schedule II or III medication concurrently for chronic pain management and mental illness.

Reexamination and Assessment for Opioid Treatment for greater than 90 days:

Reexamination must be performed by the authorized treating physician/qualified physician/Pain Medicine Specialist in person at least every 90 days (except in the special cases of catastrophic injury (defined in the Division of Workers' Compensation Rule 0800-02-07-.01(6)) and persistent pain syndromes on long term stable opioid use for over two years).

Every 90 days the physician must attest and document in the patient's chart that:

1. the medications continue to be medically necessary and appropriate,
2. the pain is severe enough and chronic enough to warrant the medications,
3. attempts at withdrawal in the past led to significantly decreased function,
4. other modalities are not sufficient,
5. the treatment is directly and primarily related to the compensable injury.

In the written report, every 90 days, the authorized treating physician must include quantifiable tests/objective documentation that includes:

1. a repeat comprehensive physical examination,
2. a signed pain management agreement that is current (less than one year old),
3. documentation of a discussion and recommendations concerning available alternative treatment options,
4. an assessment of **functional improvement** or maintenance of satisfactory activities of daily living, and/or,
5. documentation of satisfactory continued employment, employment applications or vocational rehabilitation attempts, or unemployment status,

6. dates of and results of urine drug screen tests,
7. dates of and results of checking the Tennessee Controlled Substance Monitoring Database (how many prescribers, how many pharmacies, etc., compliance with pain management agreement, etc.).

In order to justify the continued use of opioids, the treating physician must document that with the use of opioids, the pain level has been measurably improved (based on Visual Analog Scores, in comparison of pain levels without use of opioids) and there has been a definite improvement in function with the use of the opioids, as measured by an objective functional assessment tool/questionnaire.

In the absence of objective functional improvement, the physician must give a written opinion that “the present regimen is the best that can be done and that without it, deterioration in function or daily activities would likely occur. ” An annual attempt should still be made to wean/taper the scheduled medications.

This every 90 day evaluation must be done as a “face-to-face” evaluation by the treating Pain Medicine Specialist, and would be equivalent to CPT™ code 99215 in complexity.

Pain Management Agreement:

A pain management agreement should be signed and be current, updated each year, and should meet the criteria specified in T.C.A. § 50-6-204(j)(4)(D) for workers’ compensation patients on chronic opioids.

Buprenorphine, Methadone:

Medications containing buprenorphine, with the exception of the patch, should not to be used for “pain” and should be managed and prescribed only by a trained and federally qualified physician. Those taking oral buprenorphine or methadone for treatment of opioid addiction should not be prescribed additional opioids for pain after 90 days from their workers’ compensation injury. Methadone is not recommended for the treatment of pain.

Testing, Urine Drug Screens, CSMD, and Pill Counts:

Urine drugs screens or tests must occur at least twice per year for all Workers’ Compensation patients taking Schedule II, II, or IV for chronic pain management. If the patient is on doses over 100MEDD, or has a higher than normal risk for opioid abuse or diversion identified by risk assessment instruments, testing should occur at least four times yearly. If the point of care urine drug screen testing is not consistent with the known prescribed medications, reveals medications not prescribed, or is positive for the presence of illicit drugs, then a confirmation of the urine drug screen must occur with a repeat (or an additional) urine drug screen test on a specimen collected that same day and sent for testing to a federally certified lab.

Pill counts must occur at each office visit and must be consistent with the date of prescription filling and dose instructions.

The Tennessee Controlled Substance Monitoring Database must be queried at least four times yearly and action must be taken if the pain management agreement has been violated. As per T.C.A. § 50-6-204(j)(4)(B), two violations of the pain management agreement must be reported to the workers' compensation insurer, permitting the insurer to stop authorizing payment for scheduled medications.

The urine drug screen test obtained must be capable of detecting the presence or unexplainable absence of all controlled substances being prescribed, the presence of additional commonly used or commonly abused scheduled medications, and the presence of commonly abused schedule 1 drugs.

If the authorized treating physician, the pain medicine specialist, requests that the patient be seen between routine appointments for random or unannounced urine drug testing and pill counts, the patient should be reimbursed for mileage expenses at the same rate as a routine appointment.

Special Circumstances, catastrophic injuries and stable persisting pain syndromes:

In cases of *catastrophic injury* (defined in the Division of Workers' Compensation rule 0800-02-07-.01(6)) with objectively documentable source(s) of significant chronic pain: if the patient has been receiving chronic opioid therapy for over two years, the dose has not been escalating, urine drug screening has been occurring at least twice yearly with appropriate results, pill counts have been correct, and the Tennessee Controlled Substance Database reports have been appropriate, and no adverse events (overdose episodes, accidents attributable to medication use, etc.) have been documented, continued opioid prescribing at current doses should be presumed to be appropriate and medically necessary. Utilization review is not appropriate for these catastrophic injuries on stable appropriate treatment.

In *persisting pain syndromes* after a work-related injury or a work-related illness: if the patient has been treated by a workers' compensation authorized treating physician/"qualified physician" for over two years with opioid doses of 100 MEDD or less, and the patient is not also being prescribed or taking additional non-opioid scheduled medications, anti-psychotics, or "muscle relaxers," the opioid dose has not been escalating, urine drug screening has occurred at least twice in the past year with appropriate results, pill counts have been correct, the Tennessee Controlled Substance Database reports have been appropriate, no adverse events (overdose episodes, accidents attributable to medication use, etc.) have been documented, continued opioid prescribing at current doses should be presumed to be appropriate and medically necessary. Utilization review is not appropriate for these stable chronic pain patients on low or moderate opioid doses.

Pain adjuvants:

The use of Neurontin® and those antidepressants that are recognized in evidence-based guidelines as indicated for chronic pain management may be appropriate in certain circumstances as pain adjuvants and not eligible for utilization review if the prescribing physician cites the evidence based review.

Aberrant Drug Screen Results:

Absence of the prescribed medications, presence of non-prescribed medications, or the presence of illicit drugs on two confirmed urine drug screens is an indication for discontinuation of scheduled medication pain management. Tapering may be appropriate in some circumstances, but not for the opioid in patients in whom urine drug testing documents the absence of the prescribed opioid (if the patient is not taking the opioid, there is no reason to prescribe more for “tapering”).

Warnings, Weaning or Tapering:

Strong warnings and patient education should be carried out with each prescription refill about the dangers of the concomitant use of alcohol, sedatives, sleep medications, Neurontin®, and other medications that might interact, potentiate or interfere with the opioids. Violations of these warnings, with two positive urine drug screens, from a federally certified lab would be a failure to adhere to the pain management agreement and grounds for the denial of payment of the scheduled medications under workers’ compensation as medically necessary and the subsequent institution of a weaning protocol. Since there are chances, particularly with screening for alcohol, of false positive tests, each case and each circumstance must be judged individually by the authorized treating physician as to whether the violation represents a failure to adhere to the pain management agreement.

Since there is no proven long term benefit of narcotics to most patients², especially by objective measures of functional improvement or improved daily activities, an annual attempt should be made to taper all patients, except those covered in the subsequent section on “Working Patients.” This may include multidisciplinary approaches and alternative, cognitive, or other therapies, and this will require the judgment of the authorized treating physician as to the completion of the tapering to the lowest effective dose, or weaning completely off the opioid. The opinion of the authorized treating and prescribing physician shall be presumed to be correct on the matter of whether discontinuation by weaning has occurred effectively, tapering to a lower but logical and somewhat effective dose has occurred, or whether tapering has failed, and the patient should be prescribed the original opioid dose. Tapering or weaning protocols may require more frequent visits with the authorized treating physician, and the patient should be seen “face-to-face” by the prescribing physician and not by alternative mid-level providers during tapering.

Cost of Weaning or Tapering:

The cost for tapering or weaning (including medications designed to aid the weaning or tapering process) is the responsibility of the employer/insurer. Tapering or weaning on an out-patient basis should not exceed 6 months after the completion of the appeals process (*See TCA* § 50-6-204(j)(4)(E)) or once the weaning/ tapering process has started. Unless the recommendation of the employer’s utilization review is based

² Chaparro LE, Furlan AD, Deshpande A, et al. Opioids Compared with Placebo or Other Treatments for Chronic Low Back Pain: An Update of the Cochrane Review. *Spine* 2014; 39 (7): 556-63

on the absence of the prescribed scheduled medication in urine drug screen testing, as described in the paragraph above, the employer is responsible for payment of office visits and medications prescribed during weaning or tapering.

If the patient is being prescribed additional non-opioid scheduled medications (e.g. benzodiazepines, amphetamines, hypnotics, anti-psychotic medications, major or minor tranquilizers, or muscle relaxants) by the authorized treating physician ("Pain Medicine Specialist"), utilization review of these additional medications may also be performed. The co-administration of these medications with opioids significantly increases the probability of serious complications, including death, and should generally not be used. Withdrawal/tapering/weaning should be carried out one drug at a time as an outpatient. If multiple drugs are to be withdrawn simultaneously, this may need to occur in an in-patient drug treatment facility.

In-patient detoxification (preferably coupled with functional restoration) may be medically necessary in certain situations where there are extra risk factors such as, but not limited to: very high doses of narcotics or other medications, cardiovascular disease, seizure disorders, multiple medications to taper, and/or major psychiatric conditions. In-patient treatment may also be necessary if severe medical or psychiatric complications (including suicidal threats or attempts) occur as a direct result of the tapering. When in-patient weaning/detoxification is appropriate, it is the financial responsibility of the employer/insurer.

Marijuana:

The Division of Workers' Compensation does not recognize the use of marijuana for work related injuries or illnesses even if it is obtained on the recommendation from a physician in a state that has legalized marijuana for medical or recreational purposes. Two positive urine or blood drug screens from a federally certified lab for marijuana will be considered a violation of the pain management agreement (See T.C.A. § 50-6-204(j)(4)) and will result in denial of further pain management treatment under workers' compensation with Schedule II, III, and IV medications and may start an appropriate weaning protocol. Other non-scheduled medications and other non-pharmacologic modalities may continue to be reasonable and medically necessary.

Safety:

Each patient must be evaluated by the treating physician with documentation at each visit as to the patient's safety and the safety of others for work activities such as driving, operating machinery, or heavy lifting. The long term use of narcotics in younger workers that do heavy lifting is not recommended.

Certain safety sensitive jobs (as defined in the TCA§ 50-9-103(16) (B)), are in general not consistent with the taking of certain medications. The treating physician is responsible for assessment and documentation of a discussion with the patient and patient's employer as to the rationale and safety of the employee and others when the employee is a prescribe controlled substances and in a safety sensitive occupation.

The TN Drug Free Workplace Act defines safety sensitive jobs. Those individuals can be randomly tested, if the employer is participating in the Drug Free Workplace Program.

Testing must go to a federally certified lab, and the results must be evaluated by the physician Medical Review Officer. In general, use of controlled substances is not appropriate in patients who continue to work in safety sensitive jobs. Employers may designate additional job categories as “safety sensitive” and have personnel policies that prohibit use of controlled substances in employees in these safety sensitive jobs.

Working Patients:

In the special circumstance where the patient is employed at their same or similar occupation, and is taking only an opioid at less than 100MEDD and no other scheduled medication, tapering or changes in dosages should be considered very carefully and it is not appropriate for denials or dosage modifications to occur by an utilization review organization or pharmacy benefits manager without direct contact with and approval by the prescribing authorized treating physician, who will consider whether the recommendation would potentially compromise the patient’s continued employment. If continued opioid use is felt by the prescribing physician to be crucial to permit continued employment, then that opioid use will be considered medically appropriate.

Pregnant Patients covered under Workers’ Compensation:

A patient who is maintained on chronic opioids, who notifies her prescribing physician (authorized treating physician), that she has become pregnant while receiving opioids or any other scheduled medications under Workers' Compensation should be jointly managed by a “qualified physician, pain specialist” and by a high risk OB physician. Changes in dose or medications not recommended and agreed to by both physicians should not occur during the pregnancy.